

DIFFERENTIAL DIAGNOSIS OF BUTTOCK PAIN USING A FLOW CHART

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Abstract: Buttock pain is often seen in chiropractic general practice, either as the only presenting symptom or as part of a symptom complex. The following flow chart has been prepared in an attempt to assist the clinician in arriving at an accurate diagnosis and aetiology.

Key words: Flow chart, buttock pain, referred pain, differential diagnosis, chiropractic.

Most pain in the buttock has a lumbar origin and lesions of the buttock itself are uncommon and often serious. In order to reach an accurate diagnosis all the structures which can create buttock pain, ie. the lumbar spine, sacroiliac joints, buttock and hip, must be examined thoroughly and systematically. (1)

The accompanying flow chart is designed in such a manner that it commences with the lumbar spine and concludes with the conditions related to dysfunction within the buttock itself. The astute clinician would not cease their examination after the examination of one region, even if a source of pain is detected in that region, for it may well be the case that the patient has two or more co-existent conditions contributing to their symptomatology. For example a patient presenting with buttock pain due to postural stress is also likely to have accompanying myofascial trigger points within the gluteal muscles. Similarly it is imperative that both sacroiliac joints are examined rather than just the ipsilateral joint as compensatory dysfunction may occur in the contralateral joint. (2)

The cause of buttock pain by more sinister pathology is often difficult to diagnose, particularly in the early stages of the disease process. Intraspinal lesions are not apparent on plain film radiology (3), infections of bone like osteomyelitis may only be diagnosed radiologically eight to twelve weeks after the onset of symptoms, and in the early stages may be indistinguishable from mechanical backache, (3)(4) and even neoplasms only become evident radiologically when there is destruction of at least 30% of the osseous mass. (4)

However, it would be impractical, cost prohibitive, and invasive for every patient who presents with buttock pain to undergo the barrage of tests necessary to eliminate such pathologies. But if a trial of conservative therapy fails to provide the expected improvement or the patient's symptoms become progressively worse further diagnostic testing should be commenced without delay. (3)

It must also be borne in mind that this flow chart includes conditions that would mostly cause either referral or pain patterns confined not only to the buttock. Classic textbook presentations can not be expected all the time in general practice. Atypical presentations are not uncommon particularly in referred pain syndromes and therefore consideration must be given to aetiologies other than those one would normally expect to cause buttock pain alone.

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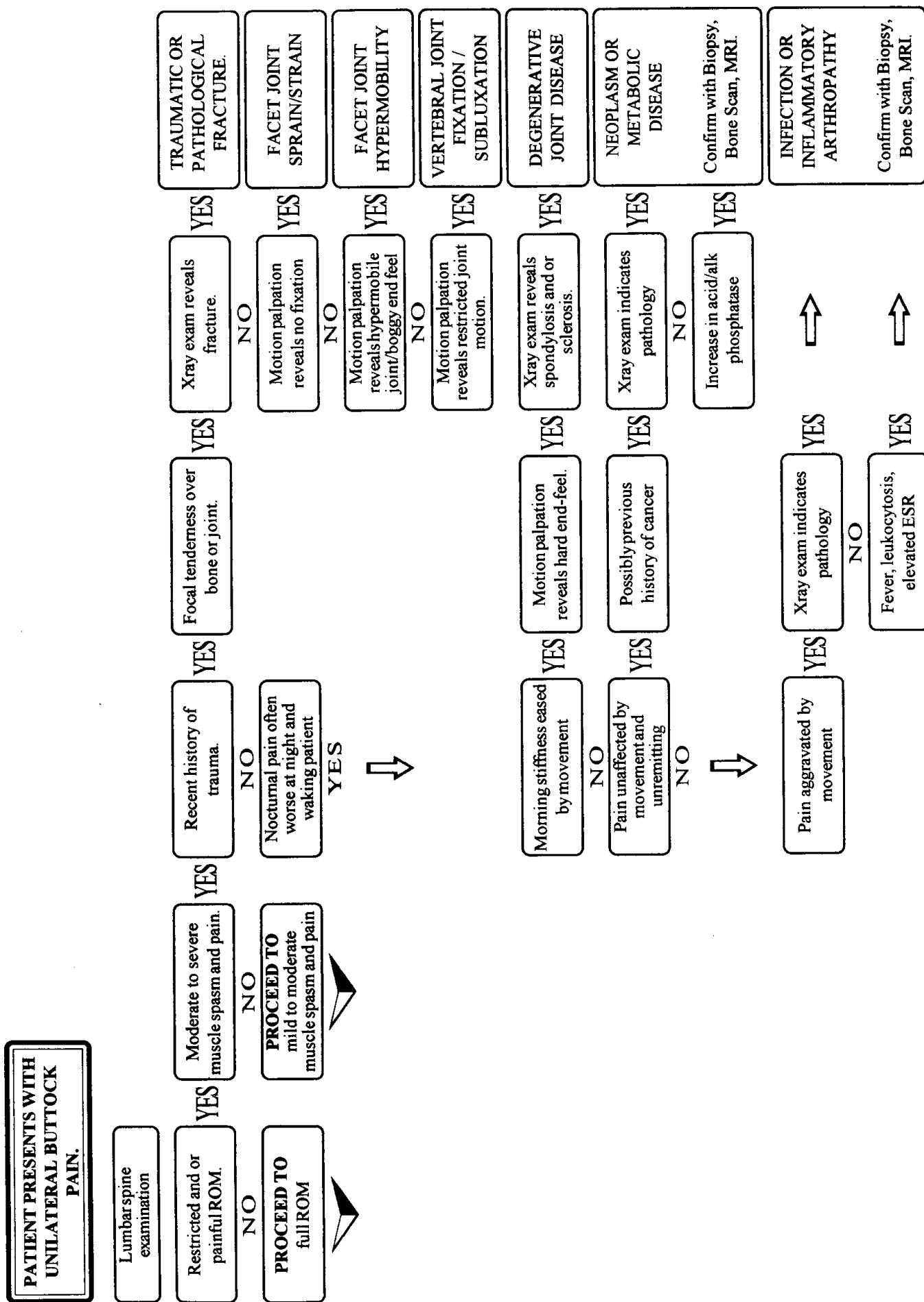
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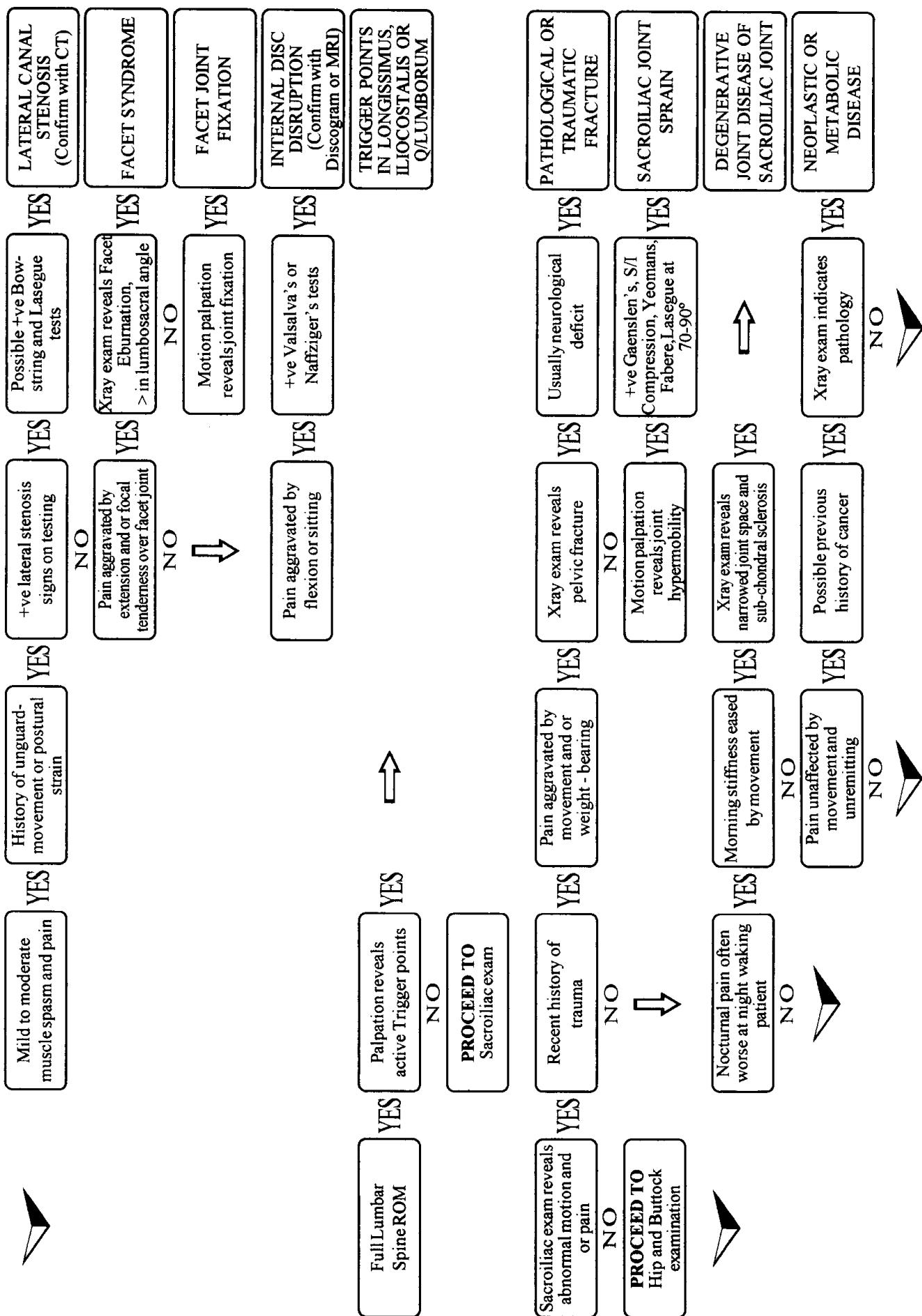
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